Maternal-Infant Health Program Design Workgroup Notes

January 21, 2005

Present: Bonnie Ayers, Dianna Baker, Lynette Biery Biery, Suzette Burkitt-Wesolek, Alethia Carr, Ingrid Davis, Paulette Dobynes Dunbar, Stacey Duncan-Jackson, Sheila Embry, Brenda Fink, Pat Fralick, Sue Gough, Deb Marciniak, Sue Moran, Sara Paas (for Judy Fitzgerald), Doug Paterson, Diane Revitte, Carolynn Rowland, Paul Shaheen, Tom Summerfelt, Betty Tableman, Peggy Vander Meulen, Darlene VanOveren (for Rick Haverkate), Kathy Whited, Betty Yancey.

Present via phone: Rosemary Blashill (for Nancy Heyns), Dianne Douglas, Mary Pat Randall, Sharon Wallace, Phyllis Meadows.

Not present: Mark Bertler, Anne Bianchi, Sandra Brandt, Sheri Falvay, Judy Fitzgerald, Adnan Hammad, Rick Haverkate, Nancy Heyns, Ed Kemp, Mary Ludtke, Rick Murdock, Jackie Prokop.

Future MIHP Design Workgroup Meeting Dates

Thurs., Feb. 17, 2005	1:00 pm to 3:30 pm	MPHI Interactive Learning Center
Thurs., Mar. 17, 2005	1:00 pm to 3:30 pm	MPHI Interactive Learning Center

Tasks / Assignments

1. Betty Tableman will send her paper on FIA work requirement policies that impede the ability of mothers to adequately parent their young children to Doug Paterson.
2. MDCH will consider the DWG's request to review the screening tool in its current iteration and report back to the DWG.
3. Sue Gough, Phyllis Meadows, and Doug Peterson will discuss Sue's request that the Detroit area be included in the IHCS MIHP-related research project.

Welcome and Introductions

Doug Paterson welcomed the MIHP DWG members, noting that our December 2005 meeting was cancelled so that Institute for Health Care Studies (IHCS) staff had time to flesh out a model based on the *MIHP Design Criteria.* The proposed model will be the focus of today's discussion.

Sue Moran reminded the group that MDCH funds the IHCS at MSU to assist MDCH with quality improvement initiatives for Medicaid and other programs. In one recent QI initiative - The Michigan Medicaid Families Project - IHCS analyzed MSS/ISS data from FY 01, concluding that we are not reaching woman at highest risk. As a result, MDCH decided to step back and explore how to improve the program. Doug Paterson noted that it wasn't possible for the DWG as a whole to develop the design from scratch by the Oct. 1, 2005 deadline, so MDCH asked IHCS to propose a model to which the DWG could react. MDCH is grateful to the IHCS and the MIHP DWG for assisting in this endeavor.

Paul Shaheen said that the current MSS/ISS screening tool screens everyone in. Lynnette said the new screening tool will stratify participants into risk levels, and that the risk level will determine the intensity of the intervention. Readiness to change will be a factor in determining level of intensity of the intervention.

Maternal Infant Health Program: Proposed Design

Lynette Biery, Suzette Burkitt-Wesolek, and Stacey Duncan-Jackson, IHCS, did a PowerPoint presentation titled, "Maternal Infant Health Program: Proposed Design". They handed out the PowerPoint slides and a one-page document titled "Michigan Maternal Infant Health Program - Program Overview/Design." Their goal in designing the program was to "create a feasible Maternal Infant Health Program that can be implemented within the time frame (10/01/05) and resource constraints set forth by MDCH", based on the goals and design criteria previously approved by the DWG. They shut themselves in a room and considered 3 different types of programs:

- case management
- fully web-based model with multiple points of entry and centralized oversight
- hybrid – enhanced current program and moving forward a fully-web-based model over a 2-3 year period
-

Ultimately, IHCS concluded that the hybrid model was the most feasible and least disruptive to current providers. It begins with the existing program structure on 10/01/05, and gradually phases in enhancements over 2-3 years, adding in the infant component at a later point in the design process.

Clearly, it will take major information technology infrastructure changes to get to the fully web-based model. However, when it is up and running, a potential client, a WIC worker, other community agency worker, etc. will be able to do an online screen. The screening data would go into an algorithm at MDCH and the individual would get an immediate reply regarding eligibility.

The core concepts of the hybrid program are:

1. Centralized management and tracking
2. Focused case finding, assessment, and intervention
3. Performance expectations and feedback
4. Reimbursement

1. <u>Centralized management and tracking</u>

    a. central registry (data base) to track services and outcomes.
        - Registry will be part of MDCH data warehouse.
        - MIHP providers will use a simple, user-friendly format to enter data (e.g., Excel spreadsheet).
        - Would track entire population – not just those receiving services.

- Women have the option of opting out of the WIC registry – will women have the option of opting out of the MIHP registry? Lynette Biery believes that MA would not require that woman be allowed to opt out of the MIHP registry, so even if they refuse MIHP services, we can still track what happens with them to some extent.
- Pregnant women would be identified by WIC, family planning, MIHP providers, community agencies, health plans, etc., and through encounter and billing data (e.g., pregnancy test), and would then be entered into the registry.
- Once a woman is entered, she may remain in registry for several years.
- Medical home providers will be able to access and enter data into the web-based registry, which will increase communication between the medical home and the MIHP provider.
- Paul Shaheen said that several physicians are eager to provide input on the registry as it is developed.

b. program management centralized at MDCH

2. <u>Focused case finding, assessment, and intervention</u>

a. Outreach focused on engaging MA pregnant women
   - Highest intensity of service to highest risk clients – currently, we are not serving many high-risk women, although they are the most likely to have negative outcomes. Pat Fralick said that statements that MSS/ISS isn't reaching high-risk women are troubling, as some providers have been more successful than others in this regard. Stacey Duncan-Jackson said that IHCS is sharing global data at this point, but that certainly there are pockets of excellence around the state, and we surely intend to learn from programs that have done a better job with access and engagement later in the design process. Lynette Biery concurred that Pat's numbers are good, and that the centralized intake / WIC process used by her program is of great interest to the IHCS.
   - Must include WIC. Statewide, WIC enrolls 80-90% of its target population, so we know WIC is serving high-risk women. We need to collaborate with WIC to screen women for the MIHP, but we have to do it without burdening the WIC staff.
   - Paul Shaheen said that several years ago it was suggested that MDCH maternal and infant health programs be bundled with the same contractors in order to be more efficient, but this was not done.

c. Targeted screening, assessment, and risk stratification
   - Providers will be incentivized for engaging high-risk women and retaining them in the program.
   - Auto-assignment will ensure that all women are served according to their risk level and guard against "cherry-picking."

d. Domains of care
   - Domains include: smoking, nutrition, chronic disease, alcohol/substance abuse, domestic violence, behavioral health, pregnancy

complications/short inter-pregnancy interval, and emergent basic needs. The literature shows that interventions in these domains of care are most likely to lead to positive outcomes. It's critical that we invest in interventions that will give us the return on our investment, as funding is extremely tight.

- Betty Tableman said that the core program objectives are written in negative terms – "reducing problems." We don't have anything in here to promote infant development – we need to include mother's attitude toward infant as a risk factor and start during pregnancy, not after birth.
- Providers will receive training and technical assistance on evidence-based interventions and will be expected to use them, but will be encouraged to adapt these interventions to their particular communities. We will want to see evidence-based interventions on care plans, but for some outcomes, providers will have to use promising practices instead, because the evidence to date is not definitive. This means that the interventions used across the state will be more consistent, however, they will not become standardized, and providers will not be required to use certain interventions. Eventually we'll develop evidence-based guidelines, and providers will choose from among proven interventions to get the best outcomes, but we know that any particular intervention will not work for all women.
- Providers will not be required to directly provide the interventions in every domain of care themselves. For example, they may refer women to community smoking cessation programs. Peer outreach, community health workers may be part of the team.
- Carolyn Rowland asked, what's built into the proposed model to ensure we're continually looking at new evidence, since it changes so rapidly? Stacey Duncan-Jackson said this would be built into the continuous quality improvement (CQI) process.

3. <u>Performance expectations and feedback</u>

   a. Performance expectations clearly defined – providers know the outcomes that they are expected to achieve in advance.
   b. Common care plan (standards/guidelines – not cookbook care)
   c. Ongoing monitoring and feedback
      - 2-way data exchange and reporting
      - Auto-assignment process (down the road) - the woman will be assigned to an MIHP provider when she enrolls in Medicaid. Auto-assignment will be driven by outcome data – the providers who are getting the best results will be assigned more women.
      - Paul Shaheen said that auto-assignment doesn't work in FFS, and a large percentage of pregnant Medicaid enrollees are in FFS. Sue Moran said that if this function is centralized at MDCH level, we could administratively develop a mechanism that will work. We're talking

about auto-assignment to an MIHP provider, not to a managed care health plan.

- Strong emphasis on CQI – it's critical to evaluate program step by step, on an ongoing basis, making needed adjustments as we go along (not wait for another 13 years).

d. Increasing expectations over time.

4. Reimbursement

There will be a shift from per-visit reimbursement to case rate reimbursement (which is entirely different from risk-based capitation). Case rate reimbursement means that providers will get different rates for different women, depending on various factors such as point of engagement in the pregnancy, the level of intensity of the intervention, retention, outcomes, etc. High-performing providers would be paid more and would be assigned more women (through auto-assignment) as incentives.

Different entities could be reimbursed for certain services. For example, WIC and other community agencies could be reimbursed for screenings only. There will be different rates for screening, assessment, and interventions.

Case rate reimbursement will allow providers to be more creative in delivering services. They will no longer be limited to face-to-face visits - they still can do face-to-face visits, but may also choose to serve women through groups, clinic visits, phone contacts, etc. The literature shows that some women don't want providers in their homes, but may be willing to engage if services are offered elsewhere. Sue Gough noted that home visits are important in that they offer providers a clearer understanding of the woman's situation. Ingrid Davis said that health departments would have an advantage over community-based providers, in that they have facilities in which to run groups, while some community-based providers do not. Lynette Biery said that it depends - women may be more comfortable meeting at a local school than at a health department. Overall, there would be some advantages to health departments and some to community providers. Sue Gough said that in her experience many women resist groups. Lynette Biery said groups would be just one option for service delivery among many, and it would be up to the provider to decide.

The case rate builds in performance incentives. For example, if a provider gets the case rate for smoking cessation for several women, but none of them quit or significantly reduce smoking, this will become evident through data reporting. Outcome expectations will increase over time.

The outcomes that we'll incentivize are the core program objectives / domains of care listed on the matrix that we have discussed at the last several meetings. These include: smoking, nutrition, chronic disease, alcohol/substance abuse, domestic violence, behavioral health, pregnancy complications/short inter-pregnancy interval, and emergent basic needs. We'll be able to collect objective data on some of these (e.g., pregnancy outcome, chronic disease), but will have to rely on self-report on others (e.g., smoking).

We will also have process outcomes such as using the registry, number of women screened, number of women engaged, etc.

Developing case rates is very complex. Data experts, actuaries, and Medicaid policy staff will have to work together on this. Again, case rate reimbursement is NOT CAPITATION.

Does Emphasis on Serving High-Risk Women Mean No More Prevention Services?

Pat Fralick asked how breastfeeding would be addressed in the new program. Lynette Biery said that it falls under nutrition. Every woman, irrespective of risk level, will get some basic educational information, which could very well include info on breastfeeding. Pat said that her county has a high breastfeeding rate because MSS/ISS teaches breastfeeding. She's concerned that the new model is tertiary prevention only – it sounds like if a woman isn't high risk, she won't get in, and we won't be doing prevention at the front end. Pat doesn't want to be cut off from serving an entire (secondary prevention) population.

Doug Paterson replied that we don't have enough money to do everything we would like to do. We don't have the funds to provide intensive intervention for every pregnant Medicaid beneficiary. We have a $24 million program and we have no way to turn it into a $54 million program. However, in the population management model, no woman is totally out. There will be a basic level of care that all women will get, although not all women will get the same intensity of services.

Sue Gough asked how we would pick up teen moms who live with their parents and look okay, but aren't emotionally stable. Doug Paterson replied that they would be in the MIHP at some level of risk/need. <u>All</u> pregnant Medicaid enrollees will be in the MIHP at some level of risk/need. Sue Moran said that we're trying to cast the widest possible net and periodically assess risk/need level, so we will be checking back with teens periodically. We fully expect that some women will move from one risk level to another over time.

Paulette Dobynes Dunbar asked if protective activities for women and infants (breastfeeding, parenting classes, etc.) would be offered only to lower risk women. Lynette Biery said that low or high risk women could participate in these programs. She noted that IHCS hasn't had in-depth discussions on parenting classes, readiness to parent, etc., but that she's thinking that classes on how to parent may be more important than CBE classes in the overall scheme of things, and that parent education is a topic that could be offered in group settings.

Peggy Vander Meulen said that we want staged screening and assessment over time because the point at which a woman is ready to hear about breastfeeding, for example, may not coincide with her initial screening or assessment. Sue Moran said that this is another useful feature of the registry – we can use it to issue reminders when it's time to check back with a woman. Stacey Duncan-Jackson said that in the population

management model, we definitely would be assessing the women throughout her pregnancy.

Stacey reiterated that we're not suggesting there aren't interventions we'd love to give to all women, but we have to trust in population management model and try to make a difference in the most promising domains of care.

Policies that Limit Ability to Engage Women in Program

Carolyn Rowland asked what's being done to assure that policy and programs (e.g., at FIA) don't limit our ability to engage women to participate. For example, women can't get released from the FIA work requirement when they're 9 months pregnant. Paul Shaheen said FIA is looking at structural impediments to raising healthy kids. Betty Tableman wrote a paper on this a year ago, and Paul Shaheen was told FIA is looking at it now. Betty will send the paper to Doug Paterson. At one point there was an agreement with FIA that parenting classes, etc. counted toward the work requirement, but when Gerry Miller left, it went out the window. Lynette Biery said that all MA programs should incentivize providers to offer services evenings and weekends. Pat Fralick noted that this wouldn't work for all women, as many have service-sector jobs and must work nights and weekends.

Screening Tool

Pat Fralick asked who is working on the screening and assessment tools? Since high-risk pregnancy is basically a nursing thing – is there a nurse giving input? Lynette Biery said yes – that Kent Co., Genesee Co., and District 10 health departments are the research project pilot sites, and that nurses and doctors from those sites are providing feedback on the screening tool, which is based on the literature. They have not yet begun to work on the assessment tool.

IHCS is about to field test the screening tool as part of the research project. They can share it with the DWG and try to incorporate comments, but not if comments are inconsistent with the literature.

Carolyn Rowland noted that ambivalence early in pregnancy is well known. How will this be incorporated into the screening tool if a women has not even accepted the fact of her pregnancy yet? Lynette Biery said that the screening tool does address ambivalence about pregnancy throughout the pregnancy.

Peggy Vander Meulen (from Kent Co., one of the pilot sites) said that we need an open process to discuss the screening tool and process. The pilot sites haven't seen each other's comments or had an opportunity to discuss them. We gave suggestions and now we need to get something back. The initial tool was a short screening tool. The second version was a mini-assessment with 3 tiers of questions. Is this the only tool? Do the nurse, nutritionist, and social worker do the next level of assessment? Lynette Biery said

that the feedback we have received so far from the participating sites has been all over the map. We can't incorporate it now – have to wait to the next stage of field-testing.

Brenda said that MDCH would consider the DWG's request to review the screening tool in its current iteration and report back to the DWG.

IHCS Research Project Pilot Sites

Sue Gough said that as a Detroit area private provider, she believes the Detroit area should be included in the field-testing of the screening tool. The Detroit area has 2/3 of the MIHP target population - if we really want to see improvements in state stats, we must ensure that the new program model will work in the Detroit area. Lynette Biery noted that two of the three pilot sites (Kent and Genesee) are major urban areas with large populations of Medicaid enrollees, and that the risk factors will be the same regardless of geographical location. The decision about participating counties was made by MDCH and IHCS. Could the decision be revisited? Could the screening tool be piloted outside of the pilot sites? Could we say we're just starting with the current pilot sites and will move out into other communities? Doug Paterson and Sue will talk after the meeting, so Doug can better understand what Sue's greatest fear is. Phyllis Meadows also would like to be part of this discussion – she believes it's important to test the tool in the most extreme case scenarios.

Role of the DWG

Brenda Fink said that today we're looking at the proposed conceptual model in general, big-picture terms. We will take major pieces and develop them in further detail. We need to determine what we can have in place by Oct. 1. For example, will the screening tool be ready for use across the state by then? Right now, it's still a research tool in process. We will have to go through MA forms process, so any form we want to go statewide as of Oct. 1, will have to be completed by spring.

A big question is how we can keep the design process moving along on the fast track to meet the Oct. 1 goal while maximizing input from the DWG at our monthly meetings and via the web site. Paul Shaheen said that the devil is in the details and that the DWG needs to see the tools to be comfortable with them and buy into the proposed model. He thought the DWG would be giving input so that when the new program goes through the Medicaid policy-making process and is put out for public review and comment, all of the major issues would already have been resolved. He hopes the DWG can see the products as they evolve. Doug Paterson said that much of the input will have to be provided through the web site, since we won't be able to have enough meetings to do everything we need to do by Oct. 1.

Brenda Fink said she likes the proposed design because it shows how we can make it manageable to move from the current program to an improved program in phases over several years. Initially, we're focusing on domains of care during pregnancy – we're not talking about parenting and tracking core infant outcomes. In Year 2 or 3, we'll build in

a more sophisticated approach to promoting the health and development of the infant. We'll make sure we're not losing well-child visits, immunizations, breastfeeding, etc., but we just can't pull it all together by Oct. 1.

We sent comments on the matrix to Lynette Biery – when will we see the next version? Brenda said it would be posted on the web site, which we hope will be up and running this week.

Paul Shaheen asked if the DWG has given feedback on the construction of the web site? Brenda said no – that it's a basic site that includes meeting notes, documents in process, a mechanism to sign up to receive updates, etc.

IHCS and MDCH will tie together performance expectations, reimbursement, and interventions and have some pieces in place by Oct. 1. As we share the details, we hope it becomes clearer to everyone.

Program Philosophy / Values

Mary Pat Randall said that the MSS/ISS forms were too negative. She'd like to see the new model be more like Early On, which builds on family strengths. The overall program philosophy is critical. Are we going to be strengths-based and agreement-based? If the woman and the provider don't agree on the outcomes, why proceed?

Paul Shaheen said that Early On is all about forming partnerships with families. The federal Medicaid tools are not at all about this. Will the new tools be family-friendly and build partnerships? How involved will consumers be in determining their own outcomes? CSHCS has come a long way on this. Doug Paterson noted that this relates more to the plan of care and that we need to consider family input, consent, and strengths-based practice when we get to work on the plan of care. The highest risk and least ready to be engaged women don't want to be found. Olds has shown that nurses can engage them more readily than other disciplines. Tom Summerfelt said that in the first year of the research project, we found the engagement process to be very critical, and that we must take this into account.

Lynette Biery said that after completing each screening during the pilot phase, we're asking women how they felt about it, question by question. IHCS looked at the literature to develop the questions, and now is getting feedback on the questions from real-world people. When we get into the evidence-based literature, readiness to change and strengths-based practice come to bear. We'll get nowhere if women don't want to make the changes we think they should make. One of our proposed outcome measures has to do with how well the provider moves the woman along the developmental tasks of pregnancy/willingness to change.

Other Questions and Notes

Q. My highest-risk women are transient and hard to enroll in MA. If they aren't MA enrolled, they won't go into the MIHP registry. Is there any chance that Medicaid outreach funding will be restored?
A. Doug Paterson said I'd love to answer yes, but don't see plans to restore MA outreach funds. (Is this something for prenatal initiative to address?)

Q. If we don't continually bring the latest info to the people in the field, this model won't work. What are the plans for this?
A. We certainly recognize there will be a great need for intensive, ongoing program support (training and TA) and we intend to provide it.

Q. Will we serve migrant women on MOMS?
A. Yes, we will make sure we do.

Note: Paul Shaheen said that Cheryl Lowe at Blue Cross has a package on depression (postpartum and other types) that she's trying to get out. She's looking for others to help market it. She also has one on obesity.

Note: Doug Paterson said that there is talk of broadening the MCIR registry to the "Michigan Childhood Information Registry" (same acronym), which would be a huge step in integrating the system. Paul Shaheen said that changes to MCIR require legislation and that help with a grassroots education/lobbying campaign is needed.

Next Meeting

Doug Paterson thanked everyone for their participation and said this was a good discussion.

Our next meeting is Feb. 17 here at the MPHI Interactive Learning Center. We'll send the handouts to people who didn't get them this afternoon along, with a reminder of next meeting date and time.